## CHOICES FOR CARE Home-Based, AFC & ERC Change Form

This form is completed by the Choices for Care case manager/consultant AFC and ERC provider to report changes for active or Medicaid pending Home-Based, AFC or ERC Choices for Care participants.

Individual Name:	
SSN:	Date of Birth:
Address (only if changed):	
New Phone Number:	
Current Setting: Traditional Home-Based Enhanced Residential Care Adult Family Care Home	
A. Nursing Facility (or Hospital Swing Bed) Admis	<u>sion</u>
Effective date of admission:	
	ed length of stay:
Nursing Facility (or Hospital Swing Bed):	
B. Termination /Withdrawal from Choices for Care NOTE: For home-based consumer or surrogate-direct services the case manager or consultant must forward	ted services or cash & counseling (Flexible Choices)
Effective date:  Died Permanent move out of state *Voluntary Withdrawal – No longer require Ch Other:	
*For voluntary withdrawals, the individual or legal reprint involuntarily terminated from Choices for Care will re	· · · · · · · · · · · · · · · · · · ·
I agree that I am voluntarily withdrawing from Choicat any time.	ces for Care program. I understand that I may reapply
Individual or Legal Representative Signature	Date
Comments if needed:	
Provider Name (print):	
Agency:	Phone number:
Signature:	Data

DO NOT SEND THIS FORM TO: Department of Vermont Health Access (DVHA)
PLEASE SEND COPY to LOCAL DAIL LTCCC and DCF ADPC office. Fax 802-871-3239

## **Directions**

This form is completed by the Choices for Care case manager, consultant for cash & counseling (Flexible Choices), ERC provider or AFC Home provider to report changes for <u>active</u> or <u>Medicaid pending</u> participants in the Home-Based, Enhanced Residential Care or AFC Home setting. When completing the Change Report Form, complete <u>all sections that apply</u>.